STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005023	A. BUILDING: _____ B. WING _____	04/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESKENAZI HEALTH	720 ESKENAZI AVENUE INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for 2 State hospital complaint investigations. Complaint: #IN00132161 - Unsubstantiated, lack of sufficient evidence. #IN00123001 - Unsubstantiated, lack of sufficient evidence. Survey Date: 4/2/14 Facility #: 005023 Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor Eskenazi Health is in compliance with 410 IAC 15-1.5-2, Infection control, 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.5-6, Nursing services, Indiana Hospital Licensure Rules. QA: claughlin 04/14/14	S 000		